The Prevention Connection
NEWSLETTER

Homeless Kids 2007

—Geoffrey Birnbaum

Is there an epidemic of homeless kids today? If so, what did we do in the past that prevented this? Did it work?

I'm not sure I can answer all of these questions, but perhaps I can put some of the issues in focus. I started my career in 1971, trying to help youth who were—and needed to be—out of their homes. Thirty-six years later, I am still at it.

In the late '60s and early '70s we saw the start of a movement toward deinstitutionalization. Kids who were "running" were removed from jails. Maybe law makers and social scientists thought that would solve the problem. It didn't. Communities were still faced with the challenge of helping kids and families separated by crisis. When things were stressed, the easiest way for some families to find peace was for someone to leave. Often that meant the teenagers ran away. Without jail as an option, more kids were on the streets. Without resources to get them home, communities had to invent new ways to address their needs. This may have been the start of the perceived epidemic we are facing now.

In the early '70s and throughout that decade, communities developed shelters to provide safe housing away from the drugs and violence on the street. These shelters offered an open setting and supportive environment, with counselors on staff. The idea was to better understand and address root causes for family breakdown as versus using the threat of detention to prevent kids from leaving home. Shelters were modeled after the older model of receiving homes for abused and neglected children who'd been removed from their families and were in need of safety and care. It made sense. For many of us, it still offers the best and safest way to house kids in crisis while working toward reunification or a better permanent plan. Homes were funded with state and federal dollars and served kids placed by youth courts and by child protection workers. Looking back, this seemed to be the way communities served potentially homeless youngsters. At least we had the option . . . *if* we could locate the child and *if* the child would accept care and support. So what changed?

Those defining our youth-serving systems thought they needed reformation; lawmakers made changes to slow down or reduce the cost of human services in their budgets. In the late '80s, the federal government reduced its role in social services and shifted it to states for responsibility and funding. In response to budgetary pressure to fund services previously supported by federal sources, states shifted some social services into the mental health system, where there was still federal funding. This fundamentally changed the way we defined kids in crisis.

At the same time, many states were removing the label *dependent children* from their child protection laws, leaving abuse and neglect as the priorities for the limited resources available to protect children. No longer could a child be pushed out or choose to take flight and find financial support from the State. Soon after, juvenile justice systems moved toward community safety and accountability for youthful offenders and away from providing services in situations where there was no perceived *victim*. Families in stress and conflict were the ones who paid. The defense of this social policy fell back on the arguments of limited resources and the

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Homeless in Montana

The Vicki Column

—It was kind of fun for a while, because we knew we could go home the next day to our nice warm beds. But it made me feel bad for everyone else who couldn't. —a 17-year-old boy in Glasgow.

Recently, in Glasgow Montana, temperatures dropped to the low 40s while ten high school students spent the night camped downtown to bring attention to the problem of homelessness. Students donated blankets and put ads in the paper and on the radio, asking others to donate blankets and money. By the end of the night, the group had gathered 40 blankets to give to the Rescue Mission in Billings and cash donations that they gave to the Great Falls Rescue Mission. "I knew it was a problem in bigger cities, but I didn't know there were homeless people around Glasgow," said one of the boys.

Families are the fastest growing segment of the homeless population, so that today nearly 40 percent of homeless persons living in Montana are members of families with children. Almost sixty percent of *those* are members of single parent families with children.

Homelessness eliminates educational stability and creates huge obstacles to enrolling, attending and succeeding in school. Children who are homeless experience four times the rate of delayed development of their housed peers, and are suspended twice as often. Their health suffers: children who are homeless twice as many ear infections, five times more diarrhea and stomach problems, and six times as many speech and stammering problems. They are four times more likely to be asthmatic, and they go hungry at more than twice the rate of other children.

The frequency of violence in the lives of homeless mothers is staggering: 92 percent of homeless mothers have been severely physically or sexually assaulted during their lives. It starts in childhood: studies suggest that 66 percent of homeless mothers were violently abused by a childhood caretaker and 43 were sexually molested as children. These repeated acts of brutality result in unusually high rates of serious emotional problems and exponentially increased risk to their own children. Homeless children are physically abused at twice the rate of their housed peers, and sexually abused at three times the rate of other children.

We all have preconceived notions of what it means to be homeless. Many of us cling to the belief that *homelessness is not a problem in our town*. The reality is that the complicated sets of problems that result in homelessness can be seen at all ages and at all levels of severity on a social continuum, and that no one is invulnerable. This isn't a simple problem. The personal vulnerabilities that lead to homelessness are often generations in the making. The role of prevention is clear. The need is urgent.

In this issue you'll learn about programs throughout Montana that are working to turn this unconscionable and painful social problem around. These efforts could not be applied to a population where we could ultimately see more impact.

Vicki

Sources: National Center on Family Homelessness; Montana Survey of the Homeless 2007.

Three factors influence homelessness.

The 1st is structural—the interrelation of income, housing cost, and availability.

The 2nd is personal vulnerability, which might include mental health, substance abuse, cognitive or physical ability.

The 3rd is social policy, which can either ameliorate or worsen the other factors.

—Martha R. Burt, Social Service Research Program, Urban Institute

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Homeless Kids 2007

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belief that non-offenders didn't belong in a court system that might restrict their freedom. This left runaways and their families without options or resources. It remains a mystery what the decision makers thought would happen to these kids and parents if there wasn't *any* system to turn to.

That brings us to the present. Today's homeless youngsters fall into three categories.

Some youth are homeless because their families are too poor to afford shelter. They've been pushed out of their homes—if they ever had them. Their greatest is abject poverty, and many are homeless with their families. Whatever we, as a community, do to help these children must involve services for the entire family. Appropriate help in this case could include food pantries, emergency shelters and affordable housing. Today this kind of help is frequently provided through private and faith-based charities, sometimes with a smattering of federal funding. This system is caring, but tends to be inconsistent from community to community.

The second group is homeless kids who are in conflict at home and in families without the resources to resolve relationships. Many lack sufficient resources to purchase counseling, but for others it is the lack of the skills and ability to integrate support. These children often wind up on the streets or are at risk of being homeless. They couch surf, staying with other families or other kids who are living independently. These kids and families need counseling, a chance to resolve things at home and, that failing, funds to assist shelters and other families who might take them in, formally or informally. Currently there is no funding for this population, nor are the necessary supports in place. This lack of services and support foretells future problems and higher social costs. These disenfranchised kids learn to see the world as an unfriendly place where they must fight for what they need and want. Their disconnectedness can make them dangerous.

Many advocates argue for homeless families for the return of longer term financial support and better educational and job skills opportunities funded by government programs that can ensure services for all who seek help.

The final group is comprised of kids and families with severe emotional problems. Many—parents and/or children—are anti-social, drug abusing or unable to cope emotionally with life, stress and relationships. Without help they range further outside of the normal behaviors that communities can tolerate, and often go deeper into our criminal justice system. These youth get services when they get into enough trouble or their families act dangerous enough to force the termination of parental rights. Lacking are the interventions that might catch these issues and needs before they demand sanctions against the child and family. The separation of kids and families is never a good outcome. Voluntary services are needed before the family is at the breaking point, at a juncture where families can stay connected even when children need other care and intensive treatment. Maintaining parental connection promotes resilience, survival and growth of most any child—even when the parent cannot serve in the traditional parental role.

So what can we do for homeless kids? I suggest and dream of a voluntary and affordable family services system with a full array of tools, from counseling to family support, quality out-of-home care to effective therapies . . . all designed to connect kids to their families and families to their communities.

Almost every question can be answered through *relationship*. Homeless kids, whether an epidemic of hundreds or just one child, need chances to connect. That is their only chance for survival and growth into productive citizens. These are our kids. They deserve our best.

—Geoffrey Birnbaum has been the Executive Director of Youth Homes Inc. of Western Montana for 31 years, after working in a variety of other youth-serving agencies. He is the past president of the State Association of Children's Mental Health and Residential Providers. Geoff can be reached at birnbaum@youthhomes.com.

Youth Homes Inc.

Youngsters are referred by youth courts, probation officers, child protection workers, mental health case managers, tribal social services, and families. They can also self refer.

Youth Homes Inc.:

- *was founded on February 2, 1971, and started with a seven-bed boys' home.*
- *has now served over 8,000 young people.*
- *is located in 5 Western Montana communities – Missoula, Polson, Kalispell, Hamilton and Helena.*
- *serves children from all over Montana, giving priority to children from Western Montana.*
- *attempts to serve children close to their families and communities.*
- *offers three emergency shelters, four adolescent group treatment homes and an array of family services from foster care to adoption to birth family support services.*
- *offers a Wilderness Treatment Program in three seasons—spring through late fall.*
- *Provides emergency shelter for homeless youth in Missoula, Hamilton and Kalispell.*

Last year:

- *the average daily census at Youth Homes' programs and homes was 176 children; many families participate.*
- *Youth Homes provided 64,240 days of care and treatment.*

For more information, call 406.721.2704 or visit www.youthhomes.com.

Preventing Homelessness: A Consumer Perspective

Kenneth R. Wireman

The biggest problem is the way people look at you. The cold is something you get used to and you can always find food. But you cannot get past the looks, the quiet whispers, and the way it makes you feel. You begin to feel utterly hopeless after just a short time. Being homeless and having a mental illness makes things much worse . . . It is actually about as hopeless as you can get.

It is almost impossible to stay on a medication schedule while living on the streets. If you have delusions or paranoia, you have to counterbalance these symptoms with the notion that there really are folks out there in the middle of the night that will find you, beat you senseless, take what little money you have, and take any medications that you have. Being in a shelter is not much better. Sleeping is very difficult. Any symptom of mental illness is aggravated by being on the streets or in a shelter. Having a stable long-term place to live is what you need to work on your mental health recovery. Not just a place to stay or a program to count on, but a real place to call your own.

Source: The Journal of Primary Prevention. Special Issue. Homelessness and Mental Illness: Perspectives on Prevention. Volume 28, Numbers 3 – 4. SAMHSA Homelessness Resource Center. Published online: 5 June 2007 http://www.homeless.samhsa.gov/

Notes from the Edge: *Joseph—a.k.a. the Wolf*

—Dana LaBoy

The first time I saw "Joseph" was on a cold September morning. I was wearing a winter coat when I arrived at St. Paul's Methodist Church at 7 A.M. to set up for the *Way Home*, an event to help homeless persons access services, food and warm clothing. On my way in, I noticed a man sleeping on the concrete. He was wearing a tattered tweed coat and worn camouflage pants. His long hair was grey and matted, sticking out under a green cap. His beard was discolored. When I woke him, he was trembling and looked confused, but he came inside and accepted coffee.

As the morning wore on, people came and went—volunteers, homeless people, service providers and community leaders. Joseph sat quietly, sipping coffee that smelled suspiciously of liquor. After a while, he approached the volunteers who were distributing clothing and blankets. Joseph was frail, and he had difficulty standing up. When asked what he needed, he softly replied "a backpack, a jacket and a sleeping bag." We provided that and more. He was very appreciative and when the event was over, Joseph wandered out with everyone else.

It is hard for me to understand everything Joseph says. He keeps his head down and speaks in a slow, deep mumble. I learned that he grew up in an affluent family in Cambridge, Massachusetts. When he was 15, he dropped out of school. It was the 1960s when he left Massachusetts and hitchhiked to Pennsylvania. He met a few men there, "hoboes" who spent their time riding the rails. They befriended him and taught him the *ins* and *outs* of riding freight trains.

By the late '60's Joseph was hopping freights all over the country, stopping here and there for odd jobs to support his drinking habit. He spent his time traveling back and forth between Minneapolis and Salt Lake City, usually stopping in Montana and Idaho along the way. By the late 1980s, Joseph could not a recall a day of sobriety in 25 years.

Through his travels, Joseph had heard people mention Billings as a promising place for making a change. There was employment and he had friends he could "bunk up with" for a while. Tears welled in his eyes and his voice cracked as Joseph talked about his time in Billings. It was a turbulent period. He spoke of being in love, but when the love of his life moved on, he left Billings and wound up in Helena, where he spent the next few years . . . staying at the shelter if he was sober or in the woods when he was drunk and had nowhere else to go. In 2006, Joseph began having medical problems.

Last December, I heard he was in jail. I remember feeling grateful that he had a warm place to stay. When I saw him after that, he told me he was on his way to getting sober. I ran into him again in the spring. Joseph had been in an apartment for a few months and was doing day labor in East Helena. He was trying to stay sober. As time went on, I saw even less of Joseph. We would cross paths occasionally at the library, where he'd sit reading Kerouac, or I'd see him walking down the Gulch. He always went out of his way to greet me with a "*Hey, Lady!*" and a hug. Last I heard, Joseph had lost his apartment. Some say he went back to Billings.

During my time as a VISTA with the Montana Council on Homelessness, I learned that even though Joseph matches the stereotype for homelessness, he is the exception rather than the rule. It's easy to walk right past people like Joseph, but I count myself blessed that I didn't. He gave me a glimpse of who he is. It took courage to share his story and to let me see the person hidden behind the matted beard and the camouflage.

—Dana LaBoy came to Montana from New Jersey, and served as a Prevention Resource Center VISTA. Her term of service is up, but she made some lasting contributions. Dana has decided to stay in Montana for the time being, and is currently the Community Services Ministries Coordinator for Good Samaritan in Helena.

Pathways to Success

—Barbara Burton

—At Florence Crittenton, we believe that the birth of a baby offers a unique opportunity for change and growth in the life of a teen mother and her extended family.

Sarah came from a very abusive (physically and emotionally) home life. She is the oldest of six children and often had to sleep on the couch in her parent's home because there were not enough beds for everyone. Her dad was a recovering alcoholic who became very violent when drunk. Sarah's mom was verbally and physically abusive; she kicked Sarah out of the house after a fight, leading to Sarah's panic-stricken search for a safe home. She was homeless and pregnant. She bounced around from one friend's house to another, even spending a few nights on a park bench. When she heard of the *Pathways to Success* program at Florence Crittenton, she got in her car and drove 10 hours, by herself, to Helena.

As a society, we are sadly familiar with teen homelessness, but the topic of homeless pregnant or parenting teens is not common in Montana. The actual number is difficult to calculate. While many are literally sleeping in their cars, some are "couch surfing"—staying wherever they can find a spot for the night. According to the Center for Law and Social Policy, teen parents are "undercounted, untracked, over sanctioned and underserved." Without accurate data, the funding available for services is minimal, leaving teens and agencies to figure out possible solutions.

The Pathways to Success transitional living program at Florence Crittenton helps homeless pregnant and parenting girls ages 14 to 21 transition to independent permanent housing.

Issues faced by homeless teen parents are even more complex than those faced by homeless persons in general. Teen parents are not simply younger versions of their older counterparts. They are still involved in their own mental, physical, and social development, but must mature quickly enough to parent a child.

A multi-disciplinary team approach including education, childcare and relationship-based programming provides the best solution to help teens face the monumental task of parenting. Completing high school and continuing their educations can break the intergenerational cycle of poverty. Barriers to succeeding in school can include finding quality childcare, catching up on missed years of school and staying accountable for attendance. Childcare should include early intervention services, as children of teen parents are at greater risk for development delay.

Relationship-based programming supports positive change through therapy, counseling, and 24-hour care by addressing issues such as substance abuse, physical, emotional, sexual abuse and mental illness. Job and life skills are also of key importance for a successful transition into adulthood.

Ultimately, however, the bond between parent and child is the most important and least tangible component—and therefore the most overlooked. The first three years of a child's life are crucial in terms of development and a solid bond between the parent and child is essential. Through attachment-based therapy, teen parents can learn the vital role they play in the child's well being. At Florence Crittenton, our bonding curriculum begins during pregnancy and follows through birth and parenting. By video-taping mother and child together, therapists are able to capture moments of parenting to explore with the teen.

As for Sarah, she worked through her program and had a healthy little girl. She finished school and now lives on her own. She calls back to Florence Crittenton regularly to share her gratitude with the staff.

Providing teen parents with support, counseling and resources can change their outcomes dramatically. With so much at stake, it only makes sense to invest in the future of two generations of our children.

—Barbara Burton is the Executive Director of Florence Crittenton. For more information, visit: www.florencecrittenton.org/about/success.php.

Florence Crittenton specializes in therapeutic residential services for pregnant and parenting young women, ages 12 to 21. Many girls served have experienced multiple personal challenges including substance abuse, depression, truancy, and runaway. Our treatment model is a relationship-based cognitive/behavioral approach with a particular emphasis on attachment and bonding. This enables healing to occur and creates healthy relationships.

In our experience, in order for a teen to form a strong attachment with her baby, she must experience a positive, trusting relationship with a caring adult. She must also address mental health and chemical dependency issues. In order for this to happen, every staff person at Florence Crittenton invests significant time and effort into forming healing relationships with each girl.

Partial funding comes from a grant from the Department of Housing and Urban Development.

Foster Youth and Homelessness

—Heather Winters

—By some accounts, 40 percent of people living in homeless shelters are former foster youth.

Each year, approximately 20,000 American youth age out of foster care and are expected to live independently. Currently, 1,700 Montana children are in foster care; nearly 100 will age out this year. They will be at high risk because they lack familial, economic and social resources, have limited education and employment experience, and receive relatively poor mental and physical health services. All lead to a strong likelihood of unwanted outcomes, including homelessness.

In the U.S. today, there is a huge overrepresentation of homeless individuals who were in foster care as children. Consider that former foster children in California comprise less than 0.3 percent of the state's population, but an estimated 40 percent of those living in homeless shelters.

Youth are at high risk of physical and sexual abuse while on the streets, and may be at even higher risk in homeless shelters. Local and regional studies report that 15-20 percent of homeless youth are sexually assaulted, and more than half are "beaten up" while on the streets.

In 1986, the Social Security Act was amended to include the Title IV-E Independent Living Initiative. This provided funding to assist foster youth with transition from foster care to independent living. Between 1986 and 1998, these funds were limited to current foster youth between ages 16–18 years of age. States had the option of continuing services and support after the youth aged out, but did not receive additional funding to do so. The amendment specifically prohibited use of funds for housing stipends or transitional housing programs. Not surprisingly, most foster youth exited care into homelessness.

By 1999, a substantial body of research concluded that despite the funding, the majority of former foster youth failed to achieve self-sufficiency. Within two years of exiting the foster care system, 60 percent had been homeless for at least one night and and 35 percent had accessed public assistance.

The John H. Chafee Foster Care Independence Act of 1999 was created to assist with transition from foster care to independent adulthood. It doubled federal funding for independent living programs from $70 to $140 million. The purpose was designed to provide states with the flexible funding for financial, housing, counseling, employment, education and other supports and services targeted to former foster care recipients, ages 18 to 21. This funding was designed to compliment the youth's efforts to achieve self-sufficiency.

Chafee replaced Title IV-E and significantly changed services for former foster youth. The most important change was the federal mandate that states use a portion of Chafee funds to serve former foster youth up to age 21. Chafee also included provisions permitting optional state participation in extending Medicaid coverage to age 21 and using up to 30 percent of Chafee funds to provide housing assistance.

The Chafee program in Montana is called the Montana Foster Care Independence Program (MFCIP). Currently, the state contracts with several agenies to provide resources and outreach to current and former foster youth in Montana. Montana spends 10-15 percent of its Chafee funds for housing assistance, but does not participate in the optional Medicaid extension.

Many have argued that the housing needs of former foster youth have not been met despite additional funds. If, for example, states made all federal funds allowable for housing under the CFCIP available, each youth would receive less than $800 per year.

About 40 percent of eligible foster youth access Chafee services. Of those, few have adequate housing assistance. In a study of 19-year-olds who had aged out of foster care in three states, approximately 14 percent had experienced homelessness since leaving care. A national study found that one in four experienced homelessness. That's important to remember when you see homeless adults, because it is quite possible that they are homeless partially because of systems that failed them as children.

—Heather Winters is the Program Officer overseeing the John H. Chafee Program for Montana. She can be contacted at hwinters@mt.gov.

Great Links

Some of the organizations committed to preventing and ending youth homelessness are:

– Montana Council on Homelessness (www.mtcoh.org);

– The Child Welfare League of America (www.cwla.org);

– National Alliance to End Homelessness (www.naeh.org);

– National Foster Care Coalition (www.nationalfostercare.org);

– National Network for Youth (www.nn4youth.org); and

– National Coalition for the Homeless (www.nationalhomeless.org).

Research on youth who age out of foster care suggests a strong correlation between foster care placement and later homelessness. What happens to people as children has a lifelong impact.

Second Chance Homes

—Laura Harper

—Vision without action is a dream. Action without vision is simply passing the time. Action with vision is making a positive difference.
—Joel Barker

Conventional wisdom acknowledges the power of collaboration to make a vision a reality. The *Second Chance Homes* project in Billings is a concrete example.

Three years ago, a foster parent and the local Family Drug Court saw that treatment for chemical dependency and prevention efforts focused on the children of addicts are constantly compromised by the struggle to meet basic needs (e.g., food and shelter), and the opportunity to learn or practice life-skills (e.g., parenting and cooking). These women dreamed a vision, then convened a community meeting. The result was Roots of Promise: the Alliance for Children and Families and the beginning of the Second Chance Homes project.

The vision was an important one. On any given day in 2004, 360 Yellowstone County children were placed in out-of-home care. Of these children, 70 percent were identified as having at least one parent with substance abuse issues.

From June 2001 to May 2005, 42 of 47 adults admitted to the Yellowstone County Family Drug Treatment Court were female, and 57 percent of the children served lived in foster care at the time of admission. Studies show that youth who have ever been in foster care have higher rates of illicit drug use than youth who have not been in foster care. Several national studies of foster care alumni also show that about 25 percent were homeless, half unemployed, a third on public assistance, and 84 percent had gone on to become parents themselves.

Over the last three years, the coalition has engaged over 30 stakeholders in research, business and operations planning, securing a location and funds. In September, the Second Chance Homes project was awarded a five year, $2.5 million grant from the U.S. Department of Health and Human Services.

Second Chances Homes will begin breaking the cycle of addiction through five homes.

1) An intensively structured home for women and their children (24-hour-a-day, 7-day-a-week staff). This home is for addicted mothers who have temporarily lost custody of their children, or who are at risk of losing custody. The home offers the opportunity for children to remain in the care of their mother in a secure environment. Mothers will participate in treatment programs, receive one-on-one parenting instruction, individualized services and referrals to address mental health issues, domestic violence, long-term housing needs, job training, and life-skills. The home will also provide prevention programming and support groups for the children, with the intent of helping them build resiliency as part of their recovery process.
2) Two sober and supportive living homes will serve addicted parents not yet ready to have children in their care, but who need housing to begin the process. One home will be for men and one for women.
3) Two sober and supportive living homes will act as a step down for families leaving Second Chance Home. One home will serve men, the other women; both will provide a preventive placement for families identified as at risk, but who do not require legal involvement with Child Protective Services.

The four sober and supportive housing units will not be staffed full time, but will have case management and on-site services. All five homes are expected to increase the well-being and permanency outcomes for children affected by methamphetamine addiction or other substance abuse disorders. In addition, the homes are expected to save the community at least $10 million over time, thanks to the vision and a group of unlikely heroes.

—Laura Harper, M. Ed., LAC, is a Prevention Specialist with the Journey Recovery Program/Mental Health Center in Billings, Montana. For more information, visit www.secondchancehome.info.

Source Cited: Facts About Children in Foster Care: www.foster caremonth.org

Second Chance Homes would not exist without help from some unlikely heroes:

- *Rachel Hulkower, a 21-year-old from North Carolina, who came to the project from the Prevention Resource Center in Helena as a VISTA. While living in poverty for the year, Rachel led the first planning phase.*
- *Amanda Skinner, a 21-year-old from Texas, followed in Rachel's footsteps, helping the project for the next year as a PRC VISTA.*
- *A generous Realty company, Wulf & Associates, donated time, commissions and more to enable the purchase of property.*
- *The family who owned the property had been at the location for three generations. As part of their legacy to the neighborhood, they made generous donations toward the home.*
- *Community members offered good lines of credit and purchased the properties on behalf of Second Chance Homes.*
- *The Family Tree Center, a non-profit, donated part of the proceeds from their annual fund raiser.*
- *Michael White, a local landscaper, is working on the yard: fee $0.00.*

Homeward Bound

—Theresa McCarthy

Homeward Bound Residents often have combinations of a number of disabilities, including mental illnesses, substance abuse disorders, developmental and physical disabilities. Many are also the victims of domestic violence.

— 25% of those served meet the HUD definition of Chronically Homeless.

— Over the past 12 years, Homeward Bound has served 817 individuals and 99 families.

— 75% of all families ultimately moved into permanent housing.

— 60% of all individuals moved into permanent housing.

Homeward Bound services include:

— Alcohol and/or drug abuse services (evaluations and treatment)

— On-site intensive case management

— Childcare referrals

— Education services

— Employment assistance

— Health care services ,on-site

— Housing placement

— Life skills training, on-site

— Mental health services and referrals on-site

— Outreach

— Transportation assistance

Homeward Bound helps homeless families and individuals make the transition to permanent housing. By providing long-term shelter in combination with support services, Homeward Bound helps eliminate or diminish barriers to self-sufficiency and facilitates successful reintegration to the community.

Homeward Bound is a transitional housing program for homeless families and individuals. The program has been serving the homeless population in uptown Butte for over twelve years.

Homeward Bound residents come not only from Butte, but from cities throughout Montana. Outreach occurs through a combination of direct contact, referrals and coordination with other agencies.

Homeward Bound has effective referral arrangements with the Montana Chemical Dependency Center (MCDC), Montana State Hospital (MSH), the Montana State Prison (MSP), Butte Rescue Mission and Safe Space. The Homeward Bound case manager interviews people onsite at these facilities if they meet the homeless criteria. Approximately 50 percent of our residents come from MCDC, MSH and MSP. Other referrals come from probation and parole officers and other agencies throughout the state.

The majority of adults served are chemically dependent, have a diagnosed mental illness or co-occurring disorders. A partnership with the Butte Family Drug Court program has produced outstanding results in helping parents committed to changing their lives reunite with their children in a safe, drug- and alcohol-free environment.

Homeward Bound provides not only a place to sleep, but support aimed at helping homeless people overcome barriers to independent living. Residents may stay at Homeward Bound for up to 24 months, giving them the time to become strong and independent, and providing the tools necessary for achieving economic and personal self-sufficiency.

By design, the Homeward Bound program recognizes that a person's *choice* of whether or not to participate in services is key to success. The program employs an interview process at which time individual eligibility is determined. During intake and the first few days in residence, social barriers are self-identified.

Intake packets include a checklist of mainstream health and social services programs, such as TANF, Medicaid, SCHIP and Food Stamps. Once issues, needs and appropriate services have been identified, the case manager assists the participant in applying for appropriate mainstream programs. Assistance includes setting up appointments, helping with application work, and providing transportation to and from service sites. The case manager also follows up on each application to ensure that it was filed properly and that the participant receives the benefits to which they are entitled.

Butte has an extremely strong social services network, which established a program in 2001 called *Feed the Homeless, We Deliver*. Three times a week, deliveries of hot soup and food (as well as information on available services) are made to sites where homeless people are known to congregate. Homeward Bound's staff plays a major role in this group. Other organizations involved are Western Montana Mental Health, Butte Rescue Mission, Butte Food Bank, Human Resources Council XII, Health Care for the Homeless and Safe Space. Health Care for the Homeless also operates a free clinic twice weekly at Homeward Bound; the case manager of Homeward Bound is available during the clinics to do outreach.

Homeward Bound is a project of the District XII Human Resources Council. The program occupies a 115-year-old building that once housed offices for the Anaconda Minerals Company. The building was acquired through the efforts of the Butte Silver Bow Interagency Task Force on Housing, an organization of over 25 local organizations. The Task Force acquired the building, then adapted it for use as the transitional housing facility it is today.

For more information, contact Theresa McCarthy, Manager of the Housing, Supportive Services & Youth Employment Program for District XII HRC. She can be reached at 406.782.8250 or tmccarthy @montana.com.

Homeless in Helena

—Dave Morey

I was at a meeting recently where the Lewis and Clark County Indigent Burial Officer stated that in the many years he has been burying indigent people for Lewis and Clark County, he had not seen much change. An old railroad rider would get off the train, take his last breath and be buried in the county cemetery. That is until recently. In the last few years, he said that he has buried far more indigents who *were* from the Helena area than who *were not*.

In another recent conversation, I was told by a Helena City Police officer that there are groups of teenagers living in abandoned buildings and vehicles, unable or unwilling to go home to their parents. Just last week I met with a 22-year-old pregnant woman with a 2-year-old son. They had no place to live because her boyfriend had kicked her out of the trailer they shared.

I have never been homeless, so I cannot fathom how it must feel to be in such a vulnerable, desperate situation. But I do know many people in the Helena community who are without a home. The Office of Public Assistance staff has contact with them every day.

What is going on here?

The reasons for homelessness are as many as there are homeless people. Those of us who work in human services are familiar with domestic abuse, mental illness, unemployment, the high costs of rent and so on. There are abundant statistics and facts about how many people are homeless at what time of year and why. But when you sit and talk with people who have no homes, it becomes clear that what brought them to that situation is far more complex than any reason or statistic. In reality, this situation is beyond any rational understanding. Though they may have shelter, they have no home, no place of their own, nowhere they can go at night and feel secure and loved. This is unacceptable.

It makes sense, without having to be told by a sociologist, that without a home, other issues become enormously complex, especially when children are involved. If we are ever to break the cycle of poverty, as a society we need to make a deeper commitment to confronting homelessness, just as we have done with combating hunger. There are food programs that have gone a long way to ensure that no one will starve. Having a home is just as basic a human need.

—Dave Morey is the Director of the Lewis and Clark Office of Public Assistance. He can be reached at DMorey@mt.gov.

Who are our homeless neighbors?

The night of January 31, 2007, volunteers identified 2,217 homeless persons in Montana. The "typical" homeless person could be male or female, young or old, Native American or White. One in three homeless adults between the ages of 18 and 64 is working part- or full-time. The majority have been in the cities where they are homeless for at least a year; and 31 percent have been in the area for 10 years or more.

For more information, go to the 2007 Survey of the Homeless: http://nth-degree.com/mthomeless/svg07.html

Kids Leading the Way

—They look in your eyes to find trust and you shouldn't look away.
—Andrew, 12.

Last year, sixth-graders at Independent School in Billings made a big difference. Their teachers, Darcene Butler and Christine Rodacker, told the 39 students in their classes, "You need to give back to your community, You need to learn our community is a part of you. You need to nurture your community."

The students took it seriously. They collected toothbrushes, soap, deodorant, shampoo, shaving lotion, wash cloths and wet wipes—enough to fill 55 hygiene kits. They brought in socks, hats and gloves, items most needed by homeless persons this time of year.

The class also participated in Wal-Mart's KIDS Recycling project. For every bin they filled with plastic grocery-store bags, they earned $5. After that, they launched a school coin drive and challenged other classes to see who could bring in the most change. Ultimately, it brought in around $900, which was used to buy prepaid phone cards, gas cards and bus passes. One grandmother brought in a huge supply of fabric and the class spent part of the day making eight blankets to be distributed to PATH (Projects for Assistance in Transition from Homelessness) clients once they find a place to live.

"It's always kids who set the example," said Carmen Gonzales, PATH Team Lead.

The Many Faces of Addiction . . . *and Homelessness*

—Mona L. Sumner

While the relationship between homelessness and drug addiction, nationally, seems to be a controversial issue without much consensus about whether there is a causal relationship, we in the addiction treatment business have observed high rates of homelessness among the populations we treat. Even so, most persons with alcohol and drug addictions do not become homeless. On the other hand, a person with an addiction disorder who is living on a low income and is under-educated has a greatly enhanced risk of homelessness. These individuals typically have little or nothing in terms of social support systems and their jobs—if any—are often menial and poor paying.

It is not surprising that the rate of homelessness among male addicts living on low incomes may be in excess of 54 percent for those in their late teens and 20s. We have seen this group over-represented in our misdemeanor drug court in Billings. This doesn't mean that women aren't facing the same issues. While nationally more male addicts than female are homeless, it's nearly 50/50 in our drug court population.

Homelessness among this young population looks very different than what we think of as the traditionally homeless person. Our drug court population *bunks around*—staying with peers versus staying in camps or on the streets. This means that they are a more hidden homeless population. We have found safe, drug-free housing essential for positive treatment outcomes for this population. For this reason, we opened our Sober Housing Program three years ago, which has since grown from one to three houses with two more about to come on line. We simply can't keep up with demand for housing for the low-income, homeless and youthful addict.

Sober housing residents, many of whom are involved in our drug court or jail-based treatment project, have generally been abusing substances since their early teens. As a result, they are developmentally arrested and in need of habilitation services. Case management is an essential component of the treatment and discharge planning process because it helps assure that the newly recovering individual acquires a job and accesses the community services s/he needs. For this population, we believe that addiction precipitates (and often sustains) homelessness.

Family drug courts encounter familial homelessness in significant numbers in our state. The Yellowstone County Family Drug Court serves parents who are at risk of losing or have already lost their children due to their addictions. During the initial three years we were involved, well over 35 percent of participating families were homeless.

Another point of entry to the Foundation's treatment system by homeless persons is through our medical detoxification unit where upwards of 700 patients are admitted each year. Nearly half are homeless men, many of whom are veterans. This face of homelessness generally looks more like the stereotypical view of the homeless person who lives under bridges or in camps, utilizes the services of the mission and may be seen panhandling on our streets.

This population is highly disenfranchised. Social supports and family systems have unraveled. Nationally, these individuals are twice as likely as other homeless populations to be arrested or jailed—mainly for misdemeanors. This is an older population and, in our experience, Native American people are over-represented here. This is the population that is considered chronically homeless. They are often in very late stages of addiction with the resulting health problems, (e.g., advanced liver disease or hepatitis). This population is a target group for Healthcare for the Homeless, mission services, mobile soup kitchen and other outreach programs. There is little sense of hope among those who fall into this category—that treatment will change anything or that it will be worthwhile. In contrast to our other homeless "faces," this group seldom enters any part of the treatment continuum.

Another surprising point of entry for our treatment continuum is our long-term program for addicted mothers with children under age twelve. I recall being shocked when I compiled the first year outcome data for this group and found that 55 percent were homeless . . . either living with their children in cars or bunking around with peers and male partners. More shocking yet, most of the other 45 percent had no permanent housing and were not eligible to rent due to unemployment.

It is hard to think of small children living under the conditions our Michel's House children were in prior to admission to our program. These children arrive with few if any toys, no books and very limited clothing. The level of parental neglect resulting from addiction is so significant that our first priority for these children is a health examination and a developmental assessment. In these families, addiction is the cause of homelessness and child neglect.

Most of our moms are young, ranging in age from 20-32, have at least one child in their care and often come from chaotic, dysfunctional and addicted families themselves. For these women, homelessness often began with self-emancipation from their family of origin where they were abused, neglected, or found family life so stressful that they fled.

We believe the top needs of the homeless addict, regardless of age, gender, or profile to be:

— Addiction treatment;

— Health care including care for co-occurring mental disorders; and

— Transitional housing.

It has been an amazing experience to provide our specialty programs to this complex, high-needs population. While this has been challenging, it has made us a stronger organization with a much more robust range of services.

—Mona L. Sumner, MHA, ACATA is the Chief Operations Officer for Rimrock Foundation. For more information, visit Rimrock Foundation on-line at www.rimrock.org.

Hope for a Future

—Larry Gaalswyk

—Money invested in reducing recidivism saves money and brings hope to so many who desperately need a hope for a future.

Montana's T.E.A.M. Mentoring ReEntry Program has been offered at the Men's Prison in Deer Lodge for ten years. It is all about bringing hope for a future, where hope is desperately needed. People coming back to the community after being incarcerated need to know that they can succeed in a productive lifestyle.

At this point, I have assisted over 700 prisoners in the Montana ReEntry Program and have worked with approximately 145 ex-prisoners in the community. The experience has helped me learn about some of the greatest needs and challenges faced by ex-prisoners. The faith-based T.E.A.M. Mentoring Program was developed to address what appears to be the greatest need of an ex-prisoner: relationships.

Of the 700+ adult offenders in our Montana ReEntry program, there haven't been more than 10 who had homes that would provide a clean and sober environment, with positive social influences to return to.

Since 1980, the nation's incarceration rate has tripled, while the nation's population has remained stagnant. One in seven people has been charged with a felony and one in 32 has been incarcerated. Half of those incarcerated come from broken homes.

The T.E.A.M. initiative was born when I attended a conference in San Francisco that addressed prisoner transition. One presentation was on the Level of Service Inventory (LSI), a testing tool developed by Don Andrews, Ph.D. and James Bonta, Ph.D. of Multi-Health Systems Inc. The test is administered to soon-to-be-released prisoners as an assessment to determine the greatest risk factors in the prisoner's life. Nine factors are measured: Criminal History; Education/Employment; Family/Marital; Accommodations/Housing; Leisure/Recreation; Companions; Alcohol/Drug Addiction; Emotional/Personal Problems; and Attitudes/Orientation. Almost inevitably, "Companions" ranks as the greatest risk, with "Leisure / Recreation" a close second. Right behind are Accommodations/Housing and Alcohol and Drug Addiction.

More than 2,000 Montanans will be released from prison this year. Many others will be released from federal penitentiaries and county jails. T.E.A.M. was developed to meet the greatest need of returning prisoners, which is for healthier, supportive relationships.

Anyone released from a corrections environment is up against tremendous odds. Ignoring their needs does not reduce crime but can actually incite it. Without a safe place to live, food, clothing and gainful employment, people are trapped in a cycle of desperation. Without healthy alternatives, people will often return to what they have known. Meaningful relationships with people who are "doing LIFE right" Teaches, Encourages, Assists and Models (T.E.A.M.) a healthy lifestyle.

As a society, if we want to save money, we must provide safe housing and help people meet their basic needs. The cost of housing an inmate in Montana ranges from $60 to $92 per day or $30,000/year. On the other hand, money invested in reducing recidivism saves money by preventing crime, lowering the number of prisoner's incarcerated, and brings hope to so many who *desperately* need a hope for a future.

Money that we are now spending on building prisons to house more and more of our population could be better spent on the holistic and comprehensive programming that give people a chance to succeed . . . from safe housing to meaningful relationships.

—Larry Gaalswyk is the Executive Director of T.E.A.M. Mentoring. He can be reached at larryg@teammentoring.org. To learn more about the program, visit: www.teammentoring.org.

Abraham Maslow's Hierarchy of Needs

Psychologist Abraham Maslow developed a specific ranking of needs in people's lives. His theory was that certain basic needs must be met before people will be moved to satisfy their other needs.

- *The most basic level: physical needs. These are things we cannot do without: housing, food, water, air, sleep. These could truly be called our life-or-death needs.*
- *Second level: safety.*
- *Third level: the need to be loved and to belong.*
- *Fourth level: the need to know we are esteemed or valued by others.*
- *Fifth level: is what Maslow calls "self-actualization." We refer to it here as reaching our full potential. This is the need to reach beyond what we are and to become all we can.*

Homeless in Montana

—Sherrie Downing

—"All my life I've heard how lazy homeless people are. I've only been homeless for two weeks, but this is the hardest I've ever had to work just to survive." —a woman staying under a bridge near Billings

Being homeless in Montana can mean sleeping in cars, camping, or staying with family or friends. It might mean a few nights in a motel or a few months in a transitional shelter. If things spin out of control, it can mean short-term hospital stays, in-patient treatment, jail . . . or death. While the most visible among the homeless are those living their lives on our streets, they represent just a fraction of a much larger population.

Fewer than five percent of persons who are homeless will resort to asking strangers for money—or in the vernacular, *flying a flag*. The frightening part of is that most people who are homeless in Montana are not obvious at all.

People who are homeless are vulnerable and socially isolated. Life without a stable, safe nighttime residence is dangerous and exhausting. The daily struggle to find food and shelter, to remain safe and to minimize discomfort is accompanied by constant fear and a hollow feeling that never quite goes away. For those who are homeless with children, a whole new dimension of responsibility and terror is added to the mix. Top this off with high rates of disease, physical disability and cognitive disorders and the difficulty of living this way really comes into focus.

"Jesse" is obviously homeless. He was 47 when I meet him. At that point he had been homeless all his adult life, except for a stint in prison. He's tattooed and muscular, with long, grey hair and pale blue eyes. Long ago, he was brutalized by his parents so severely that he nearly died. By age six, he was in the first of many foster homes; until he turned 18, he alternated between foster homes and juvenile corrections. He started hearing voices as a teenager and soon learned that alcohol and drugs dulled their commands to hurt himself. Every day that Jesse can find the strength to stay alive is a personal triumph. When asked what he most wanted people to know, he said, "That we aren't scum. We're people, but no one will even look at us or talk to us, most of the time."

The reasons Jesse is homeless were at least two generations in the making. His situation is not uncommon. Children who have been homeless, who have been caught in various systems, who have been abused or neglected have much poorer outcomes than their housed peers. They go on to display higher rates of mental illness, substance abuse disorders, disease . . . and homelessness.

This is particularly worrisome because families with children are among the fastest growing subpopulations of homeless persons in Montana. During the January 31, 2007 Survey of the Homeless, volunteers identified 276 homeless families with children, which together included 849 members. Many were single-parent households—young mothers with children under age 13. Domestic abuse is the most common cause of homelessness among these families. Poverty-related issues are second, even though 39 percent of the homeless parents identified were employed part- or full-time. There is simply no margin for error when people are living on incomes so tight that they must choose between heat and food and one small emergency can mean the difference between housed and homeless.

Homelessness is a social condition, not a disease. This condition presents an obvious role for prevention—at the front end, with families and children before they become homeless, and further along the continuum, when children have become adults struggling with a range of personal vulnerabilities. The causes of homelessness are interconnected; strategies to end it must also be linked. Real solutions must include safe, permanent housing and ready access to a package of services geared to the individual's specific needs. Anything less is not a solution but a band-aid.

—Sherrie Downing coordinates the Governor's Council on Homelessness and is a member of the Board of Directors of the National Coalition for the Homeless. For more information, contact Sherrie@MTCoH.org.

The Governor's Council on Homelessness has been running an informal survey to gauge public perceptions of homelessness. So far, 88 people have responded from all over the state. Just one person has never seen a homeless person in his community; two more don't remember the last time they saw one. Everyone else has seen someone who was obviously homeless within the last week.

Can you help?

Take our 5-minute survey on your perceptions of homelessness in your town. Go go www.mtcoh and click on the survey link.

Ending Homelessness in Montana: *The Governor's Council on Homelessness*

—Hank Hudson

—Real social change takes time, but it is possible if we are methodical, thoughtful and keep our eye on the goal.

Researcher Martha Burt believes that homelessness is influenced by three factors: the first is structural, or lack of affordable housing; the second is personal vulnerabilities. The third is social policy. Though homelessness in Montana is relatively new, its roots have been gaining a stranglehold through social policy for more than two decades. Low-income and affordable workforce housing have become increasingly scarce, public resources and wages haven't kept pace with rising costs, and deinstitutionalization all contributed to the crisis.

The Governor's Council on Homelessness, first established by Executive Order in 2004 and continued by Governor Schweitzer in December 2006, is charged with taking an overarching look at homelessness, then creating and implementing strategies to address it.

It sounds daunting, but over a 20-year career in state government, I've seen remarkable systems-level changes that would have seemed impossible in the beginning. One good example is seniors. Twenty years ago, there were few options for low-income seniors experiencing the natural debilitation of aging. If people needed help, they went to a nursing home. But communities, families, advocates and seniors all began asking for something better.

As a statewide community, we listened, researched innovations and looked for best practices. Collectively, we rolled up our sleeves and began implementing strategies, one step at a time. Ten years passed. Today families have a smorgasbord of options available, all designed to help seniors stay in their homes for as long as possible. Options include assisted living, Medicaid Waivers, numerous home- and community-based services . . . and the list goes on. These days, seniors can avoid nursing home care almost indefinitely, or until full-time skilled nursing care is really needed.

Awareness of the problem is a key first step. The Council has published two editions of *Homeless in Montana*, a comprehensive report looking at the issues, demographics and scope of the problem. We've established a website (www.mtcoh.org), a listserv and a periodic e-newsletter. We have engaged media at every possible opportunity. The upshot? Every day, more people begin to understand that homelessness is a problem in Montana.

To improve access to services, the Council has collaborated with the Montana Food Bank Network on a grant used to train case managers to complete food stamp applications for homeless persons. That is going well. Montana was also one of the first states that assembled a team to provide SOAR (SSI/SSDI Outreach, Access and Recovery) training for case managers. This training helps ensure that SSI applications made on behalf on homeless, mentally ill persons are approved at the earliest possible juncture. Participants report excellent success rates. As awareness grows, grassroots strategies begin to spring up. One good example is the initiation of annual access fairs for homeless people in five Montana cities.

At the end of the day, homelessness is a local problem that must be addressed locally. Since Billings has the largest documented number of homeless people in the state and a comprehensive array of services, the Council approached them about serving as a demonstration site. The result has been a successful collaboration.

After a series of three public meetings, Mayor Ron Tussing established the Billings Committee on Homelessness and assigned staff to the committee. This group has accomplished a great deal in a very short time. They've held their first access fair, *Project Homeless Connect*, and are planning a second. With seed money from TANF bonus funds as a foundation, they're putting together a funding package to house chronically homeless people. Perhaps most impressive is the way agencies are working together—the housing authority, city government, chemical dependency services, mental health services, the library, United Way, the Downtown Business Association, the Human Resource Development Council, Social Security and many others. They are looking for ways to help end homelessness in their city. Billings is energized and gaining speed. It has been an inspiration and a privilege to watch.

People frequently tell me that we can't end homelessness, but I believe it's all in the way we look at it. Anyone can become unhoused– no one is immune to unexpected catastrophe. The difference between being immediately rehoused and remaining homeless often breaks down along income lines. Those at the lower end of the economic spectrum are less likely to recover than their more affluent peers. Ending homelessness means creating the strategies and mechanisms to prevent homelessness as well as to ensure that anyone who becomes unhoused is efficiently and permanently rehoused. I think it's not only possible, but that ten years from now, we'll look back and see a constellation of solutions in place throughout Montana.

—Hank Hudson is the Administrator of the Human and Community Services Division of DPHHS and the Co-Chair of the Governor's Council on Homelessness. He can be reached at HHudson@mt.gov.

Will Work for Food

—Kate Bradford

Will work for food or *Please help I'm stranded* are phrases often hand-written on signs held by sad-looking men and women. They tend to inspire a mix of sadness, guilt or judgment. Unfortunately, the number of homeless people we pass on the street are just a small representation of the many people who struggle to meet life's basic needs. More often, women and children, a growing segment of homeless people, live in shelters or stay doubled up with other families. Called "the hidden homeless," these families pass by throughout the day without anyone recognizing their daily struggles to find shelter and food.

In a country as wealthy as the United States, it is difficult to believe that hunger is a problem. The fact that the U.S. has the highest wage inequality of any industrialized nation strongly contributes to the problem. Working full time at minimum-wage jobs far from covers the cost of living. In Montana, where housing and heating costs are high, many work two or more jobs trying to make ends meet. Families in this situation often have to choose between purchasing food and paying for things like childcare, heat or shelter.

In Montana, hunger and lack of food security are growing problems. According to annual U.S. Department of Agriculture estimates, 44 thousand families in this state who are hungry or threatened by hunger. Over the past eight years, the Montana Food Bank Network has seen an increase in the demand for food and in the number of people needing emergency food from our agencies.

First time visits to Montana's emergency food agencies more than doubled from 80,522 in 2001 to 213,895 in 2005.

Thankfully, there are government programs to help provide a safety net. The Food Stamp Program is the nation's first line of defense against hunger, providing monthly benefit cards, similar to a bank debit card, that help supplement or stretch a household's food dollars. With an average monthly benefit in Montana of $92 per person, the program brings in nearly $7.5 million federal dollars each month to our state. While more than 81,000 Montanans participate in the program, the benefits exceed far beyond those people who use them directly. In fact, the Food Stamp Program pumped $89,953,948 into Montana's economy last year, benefiting farmers, grocers and small businesses throughout the state.

The Food Stamp Program does not reach everyone who needs it. Though participation has increased by 36 percent over the past five years, Montana still ranks 38th in the nation for rate of participation in the Food Stamp Program. Nearly 42 percent of Montanans eligible for food stamps are not enrolled in the program.

The homeless and those who are at risk of homelessness in our state are most in need of outreach, and yet the 2007 *Survey of the Homeless* showed that of the homeless population surveyed, less than half received food stamps. Barriers to participation include lack of transportation, lack of a permanent address or identification, disability . . . or simply not knowing where or how to apply.

Outreach can help. Research shows that one-on-one outreach is the most successful tactic to reaching those who need help. Offering to help clients navigate the application process can make all the difference in overcoming participation barriers. As the Food Bank of Alaska points out, "People are more likely to fill out an application on their 2nd or 3rd visit—they need to hear the message multiple times."

To increase participation in the Food Stamp Program, the Montana Food Bank Network is conducting a Food Stamp Outreach Project in partnership with the Montana Council on Homelessness and the Department of Public Health and Human Services. This project offers free food stamp application assistance training to staff from various social service agencies around the state. The goal of this training is to improve access to food stamps by establishing a sustainable system of one-on-one assistance by staff to limited income adults and their

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Homeless people:

— can be eligible for food stamps no matter if they live in a shelter, on the streets, a half-way house or temporarily with a friend.

— are eligible for food stamps even if they live in a homeless shelter providing them with meals.

— cannot be denied food stamps because they lack a permanent address.

— have the option of having an authorized representative.

— should not be denied food stamps simply because of a lack of photo ID. There are many options to verify identity, including school or health ID cards, ID from other social service programs, voter registration cards, birth certificates or collateral contacts.

— have rights under the Food Stamp Program: Food Stamp offices must set up ways to serve homeless people.

For more information or to attend an upcoming training, please contact Jan Armstrong, Food Stamp Outreach Coordinator at the Montana Food Bank Network, at (406) 721-3825 or jarmstrong@montanafoodbanknetwork.org.

Close Your Eyes and Imagine

—Judy Stewart

If you can imagine not having a safe place to sleep, enough food to eat or protection from freezing temperatures, you can begin to understand what life is like for over 842,000 men, women and children in America each day. You are imagining what it is like to be homeless.

Beyond the day-to-day pain and discomfort of homelessness, it has now been recognized as a significant health risk factor. Being homeless decreases average life expectancy by up to 40 years. Recent studies indicate that the average age of death for a homeless American is between 42 and 52, as compared to nearly 80 among the general population. The death rate for a homeless man is more than five times the general population. Homeless women, 18-44 years of age, are ten times more likely to die than women in the general population. With the state-of-the-art medical facilities and services available today, it's difficult to imagine that this immense loss of life occurs before the homeless reach what most of us would consider middle aged. Even more shocking is that homeless people are not only dying from problems related to homelessness (e.g., hypothermia or untreated substance abuse) but are increasingly succumbing to treatable acute and chronic medical conditions.

In 1988, the Institute of Medicine of the National Academy of Sciences found that homelessness and poor health are strongly correlated. Unfortunately, these three correlations remain applicable today:

1. **Health problems cause homelessness:** Half of all personal bankruptcies in the US result from health problems. Bankruptcy can lead to eviction, which can easily lead to homelessness. There are also certain health conditions more prevalent among the homeless (e.g., addictions, mental illness and HIV/AIDS), all of which place people at higher risk of losing family and social supports, and at higher risk of becoming homeless.
2. **Homelessness causes health problems:** Homeless persons are more exposed – not only extreme weather conditions, but to violence, communicable diseases and parasitic infections. Health conditions are often complicated by excessive walking, standing, sleeping sitting up and lack of sleep. Poor nutrition is another

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Will Work for Food

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families. With personal outreach and individual assistance, more families are able to receive benefits available to them. The successes and challenges encountered as a result of this project will not only help to refine outreach in Montana, but also will act as a model to help improve outreach practices in other states.

The Food Stamp Application Assistance Training is a win-win. It can help service providers from other agencies integrate food stamp application assistance into services already provided. The training can also create or enhance partnerships with the county directors and supervisors from the Office of Public Assistance. The training provides a good opportunity to share your knowledge or experience with outreach with other service providers and non-profits from your area. This can help shape best practices for food stamp outreach across Montana as well as other states. Finally, there are great tools that can help direct service providers from other agencies to determine potential client eligibility using the USDA/FNS online template.

—Kate Bradford is the Public Policy Director for the Montana Food Bank Network. For more information, visit: www.montanafoodbanknetwork.org.

For more information or to attend an upcoming training, please contact Jan Armstrong, Food Stamp Outreach Coordinator at the Montana Food Bank Network, at (406) 721-3825 or jarmstrong@montanafoodbanknetwork.org.

HCH

Health Care for the Homeless (HCH) programs, are the only Federal programs responsible for addressing the primary health care needs of homeless people. The program was designed to provide temporary medical services to individuals and families while they are homeless.

In Montana, Health Care for the Homeless services are offered by Yellowstone City-County Health Department, located in Billings, Montana. They are the grant recipient for HCH funding and lead agency for HCH services in the state. Through sub-recipient agreements, HCH services are provided across a state-wide network encompassing Billings (Yellowstone County), Helena (Lewis and Clark County), Missoula (Missoula County) and Butte (Silver Bow County).

Network participants join together in building a state-wide system of HCH providers and staff who provide consistent, high quality care to the homeless populations within their communities. HCH provides access to provider, nurse, case manager, outreach worker, substance abuse and mental health services. For a listing of locations in Montana, see www.bphc.hrsa.gov/hchirc/pdfs/directory/MT06.pdf.

PATH

The goal of PATH is to find and engage people who are literally homeless, and return them to mainstream mental health and substance abuse systems.

PATH, Projects for Assistance in Transition from Homelessness, is a program created to support service delivery to individuals with serious mental illnesses or co-occurring substance use disorders, who are homeless or at risk of becoming homeless. The program funds community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services.

PATH serves those most in need—those who are literally homeless and who were previously unknown to (or had not engaged in) the mental health system. In urban areas, targeted PATH consumers are typically found in streets, shelters, and jails. In rural areas, PATH consumers may also be found in unsuitable, unstable or transient housing situations.

Successful transitions from homelessness require access to a variety of community supports and opportunities. Projects link with other services and providers to develop comprehensive approaches to service. This involves collaboration with other community-based organizations, education, advocacy and appropriate interventions for persons who are homeless and have mental illnesses.

—Marcia Armstrong is the PATH Program Manager for Montana. For more information, contact Marcia at MArmstrong@mt.gov.

Close Your Eyes and Imagine

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complicating factor that exacerbates the vulnerability of this population.

3. **Homelessness complicates efforts to treat health problems:** Health care facilities are often located far away from where homeless people stay. Many homeless people do not have cars. Those who do often cannot afford gas to put into their cars. Public transportation may be difficult, insufficient or non-existent. Without access to phones, appointments are difficult to make and to keep. Standard treatment plans are often complicated and not realistic for people who are not housed. Common remedies such as bed rest, refrigeration for medications, a sterile band-aid or a clean environment for wound care are difficult, if not impossible, for people who are homeless.

During the 1980s, there was a dramatic increase in the number of homeless people in our country. Health care professionals, shelter providers, advocates, government agencies and homeless people themselves recognized that a concerted health care response was required. With financial support from the Robert Wood Johnson Foundation and the Pew Charitable Trust, 19 cities launched four-year demonstration projects designing and implementing models to provide health care for the homeless. The successful format for these programs was replicated in the Stewart B. McKinney Homeless Assistance Act of 1986 which authorized the Health Resources and Services Administration to begin funding homeless health projects in 1988. By 2001, Health Care for the Homeless (HCH) programs existed in every state, the District of Columbia and Puerto Rico.

The first Montana HCH program was started in Billings in 1992, and expanded to three other sites by 2001. Today there are five federally funded HCH programs in Montana Billings, Butte, Helena, Missoula and Livingston. Nationwide, HCH programs provide care to 600,000 homeless clients each year. Last year, in Montana, more than 2,600 people received care from local HCH programs.

Effective homeless healthcare services must adapt to the realities of homeless people's lives, which include lack of transportation, financial barriers, need for comprehensive services and decreased ability to advocate for themselves. Medical care for the homeless is most successfully provided in nontraditional venues in close proximity to where the homeless are. HCH programs recognize and respond to these unique needs and offer care from medical providers and nurses, as well as the support and services of case management, outreach and mental health and addiction counseling.

Healthcare for the Homeless programs employ a model of care appropriate for everyone, but which is particularly well adapted to the vulnerabilities of homeless people. By creating new service delivery sites and modalities, the HCH program has contributed to the development of the healthcare infrastructure in the United States. For those who find themselves homeless, HCH remains the final healthcare safety net. The quality of care available through HCH improves the health and well-being of displaced people as well as modeling a high standard of care for all service providers.

What will it take to end homelessness?

- ***Number of Americans who have experienced homelessness: 12 million***
- ***Number of Americans who are homeless annually: 3.5 million***
- ***Number of Americans who are homeless nightly: 842,000***

Source: Urban Institute, 2001

—Judy Stewart, RN, BSN, is Director of Strategic Partnerships for Yellowstone City-County Health Department and Co-Chair of the Billings Mayor's Committee on Homelessness. She can be reached at 406.247.3292 or JudyS@ycchd.org.

Healthcare for the Homeless in Montana

Some Demographics:

— 61% male
— 93% aged 19-64
— 69% Caucasian;
8% Native American; and
18% unreported race.

Homeless Teenage Parents

—Gypsy Ray

—The average age at Mountain Home is seventeen, 50% of the residents were raised in foster care. Mountain Home received 75 referrals for service in 2006.

Just as homelessness is a concern for Montana, youth homelessness continues to be a major concern for the community of Missoula. *At-Risk Youth in Missoula: A Community Needs Assessment* performed in 2007 found housing to be one of most reported needs and gaps in service for at-risk youth.

Teenage parents cross the boundaries between homeless youth and homeless adults. If we do not provide for their basic needs, including support and training for homeless young mothers, they will become the next chronically homeless families. Minor teen parents in Missoula have very limited resources. They cannot access either Missoula's only homeless shelter or subsidized housing because of their age. Mountain Home in Missoula and Florence Crittenton Home in Helena provide the only housing programs specifically designed to serve homeless teenage mothers in Montana. Without these services, teen mothers are left to fight for the limited spaces available in housing programs for homeless families, which often cannot offer developmentally appropriate services.

Mountain Home Montana, Inc. is a private, non-profit organization founded in 1998. The organization operates three programs in Missoula: *Mountain Home*, a six unit transitional housing program for homeless teenage mothers and their babies; *Mocha Mamas Coffee Shop*, a job training program for teenage mothers; and *System to Improve Teen Services*, a multi-year grant to build the capacity of youth serving agencies in Missoula, funded since 2006.

Since 2000, Mountain Home has provided a home to over 150 teen mothers struggling with issues of homelessness, addiction, child abuse and poverty. These young mothers are often without family support. Mountain Home provides a home and a supportive staff to offer the love and guidance they need to begin build lives.

For more information about the Mountain Home, visit our website at www.mountainhomemt.org or call 406-541-HOME (4663).

At-Risk Youth in Missoula: a Community Needs Assessment

Following are the top priorities—and service gaps—for Missoula's at-risk youth, as identified by the 2007 assessment.

1. **Funding:** Universal funding needs exist across agencies and programs.
2. **Transitional services:** The largest reported gap is transitional services. These include living and skill-building programs for youth aged 18+, as well as services for: youth leaving chemical dependency treatment; families upon conclusion of family-based services; intervention youth with disabilities leaving school; and parenting teens.
3. **Increased chemical dependency treatment options:** Nearly 80 percent of participants reported that their clients use chemical dependency treatment sources in Missoula. Participants also report "atrocious" waiting lists that interfere with timely treatment. While brief inpatient treatment in Missoula is possible, many participants would like to have longer in-patient treatment options available.
4. **Crisis/emergency shelter, runaway shelter and domestic violence shelter for teens:** Many participants report a need for a place to send at-risk youth while their families are in crisis or to prevent runaway when a few days of respite are needed. Participants reported instances of youth spending the night at the police station due to lack of emergency shelter.
5. **Employment opportunities:** While there are effective and timely services from the Human Resource Council, participants would like *more* of these services to provide employment and after-school activities.
6. **Education:** Several types of education are needed, including: flexible educational models for those unable to make it in the mainstream and programs teaching parenting skills for the at-risk youth who are most likely to become parents. Parents and at-risk youth need education about available resources, as well as the consequences of high-risk behaviors.
7. **More group homes and out-of-home services:** 31 percent of participants reported a need for increased out-of-home placement opportunities. More foster homes are a pressing need in Missoula, as is more funding for group homes.
8. **Housing:** More emergency and low-income housing are needed in Missoula: 35 percent of participants reported a low-income housing shortage for their clients, especially at-risk youth transitioning from formal services.
9. **Medical and dental providers willing to accept medicaid:** 40 percent of participants reported that their clients need medical and dental care.
10. **A change in philosophy:** Nearly 65 percent of respondents suggested a pressing need for a change in philosophy relative to addressing the needs of at-risk youth in Missoula.

The 2007 At-Risk Youth in Missoula: A Community Needs Assessment is available online at: www.missoula forum.org/coalitions/mappps/index.html.

Shelter Plus Care

Since 1992, HUD has awarded Shelter Plus Care funds to serve a population traditionally hard to reach—homeless persons with disabilities such as serious mental illness, chronic substance abuse, and/or AIDS and related diseases.

In the narrowest sense, homeless individuals and families are those sleeping in places not meant for human habitation, such as cars, parks, sidewalks and abandoned buildings, or those who are sleeping in an emergency shelter as a primary nighttime residence.

The Department of Housing and Urban Development (HUD), along with many other federal agencies, funds programs to help those who are homeless. These programs are managed by local organizations that HUD calls *homeless assistance agencies*. They provide a range of services, including shelter, food, housing counseling and job skills programs.

HUD's homeless assistance programs were created by the McKinney-Vento Homeless Assistance Act and are divided into two main categories, formula (non-competitive) and competitive.

The non-competitive category consists of the Emergency Shelter Grants (ESG) program that provides homeless persons with basic shelter and essential supportive services. ESG also provides short-term homeless prevention assistance to persons at imminent risk of losing their housing due to eviction, foreclosure or utility shutoffs.

The HUD programs that award competitive funds require the development of a *Continuum of Care* in the community. This system is designed to address the critical problem of homelessness through community-based identification of needs and coordinated response. The approach is predicated on the understanding that homelessness is not merely caused by a lack of shelter, but involves a range of underlying, unmet needs—physical, economic and social.

One of the Continuum of Care Homeless Assistance Programs is the Shelter Plus Care (S+C) Program. The goals of S+C are to assist homeless individuals and their families with increasing housing stability, skills, income and self-sufficiency. The Shelter Plus Care Program provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program.

Several disabilities are targeted by the S+C program, including serious mental illness, chronic alcohol and/or other drug abuse, and AIDS or related diseases. The disability is expected to: be of long or indefinite duration; substantially impede indpendent living; and improve with the introduction of suitable housing conditions.

The Montana Department of Commerce was granted approximately $500,000 (for use over the next five years) to assist individuals statewide who meet the criteria of chronic homelessness.

This grant requires an in-kind match, normally provided through a mental health services provider. This match is essential to successful transition from chronic homelessness. Prior to this grant, only the major metropolitan areas were able to assist this population through Shelter+Care.

This program is growing slowly. At present, we are trying to get the word out to the mental health providers and advocates who can determine if the individual qualifies for this rental assistance.

Besides disbursing vouchers for Shelter+Care, the Department of Commerce and the Housing Assistance Bureau administer other programs to serve persons who are poorly housed or in need of supportive housing, but who are not homeless. These include Section 8 Housing Assistance Payments, public housing, HOME, Community Development Block Grants and Supportive Housing for Persons with Disabilities.

For more information about the Shelter Plus Care Program, contact the Housing Assistance Bureau, a part of the Montana Department of Commerce Housing Division at 406.841.2820.

Sources: Information for this article was compiled from the Community Planning & Development section of HUD's website. For more information on all of HUD's Homeless Assistance Programs, go to http://www.hud.gov/offices/cpd/homeless/index.cfm

Homeless in Montana

The annual Survey of the Homeless in Montana was taken for the night of January 31, 2007. Volunteer surveyors identified 2,217 unduplicated homeless persons. This cannot be considered a census, but it does provide a good demographic snapshot.

— 43% were unaccompanied homeless adults and youth

— 57% were members of homeless families

— 21% of all identified homeless persons were age 17 or younger

— 5% of all identified homeless persons were aged 60+

— 27% of homeless persons identified themselves as minorities, and 19% identified themselves as Native American

— Of the 2,055 persons for whom an answer was provided, 41% had been diagnosed with a disability

— Of the 2,146 persons for whom an answer was provided, 13% were military veterans

— Of 2,217 homeless persons identified, 126 met HUD's definition for chronically homeless

Source: 2007 Montana Survey of the Homeless. http://nth-degree.com/mthomeless/svg07.html.

More Great Resources

— For a list of the Homeless Services Resources in Montana, go to www.dphhs.mt.gov/contactus/homelessservices/homelessservicesresources.shtml

— For a list of local shelters in Montana, go to www.hud.gov/local/mt/homeless/shelters.cfm

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The Brain Connection: Part II

—Mary Anne Guggenheim, M.D.

This article will provide a broad overview of the processes involved in brain development from the time of conception through the first 20 years of life, at which time brain development has generally been considered "done." In reality, brain development is probably never really finished. Small numbers of new brain cells (neurons) can appear in certain areas of the brain for many years. There is also evidence that suggests synapses and neuronal networks are in a state of constant remodeling throughout life. While basic brain development occurs during our first 20 years, we traditionally describe brain development as six overlapping processes. This framework allows us to talk about, study and understand the processes more easily.

Within hours of conception, the chromosome strands (helical DNA) pair up to create a set of chromosomes that consists of a roughly equal mixture of DNA from each parent. This is followed by the process of cell division (mitosis), during which each chromosome replicates itself and separates into two sets of chromosomes that move apart. The cell divides to form two essentially identical cells. Over the next 6-8 days, sequential cell divisions occur and a microscopic hollow ball comprised of thousands of cells (called a blastocyst) makes its way to the uterus. The outer cells attach to the uterine wall to form the placenta. The inner cells form three identifiable cell layers (ectoderm, mesoderm, entoderm). At this stage, different genes turn on and off in complex sequences to determine the eventual parts of the body this primitive blastocyst will become. The ectodermal cells, which become either skin or nervous system, initially form a flat oblong plate of cells.

Neurulation is the first stage of brain development. The flat plate of cells spreads lengthwise, edges turn up and fuse together to form a tube. This neural tube is fully formed by 28 days after conception; the head end becomes brain and the rest the spinal cord and nerves. Sometimes the tube formation is incomplete at one end and/or the other. The resulting abnormality, spina bifida, is a recognizable defect that results in paralysis of the legs, bladder and rectum, among other things.

Neurogenesis is the second stage of brain development, which begins as the neural tube is forming. The several hundred million neurons of the brain are formed by the process of repetitive cell division. An almost equal number of supporting glial cells are also produced. This activity takes place centrally. Think of the neural tube as a wheel, with active cell division taking place around the axel. Primitive glial cells may actually produce neuronal cells. They also establish a radiating network of fibers that extends from the center to the outside of the neural tube. As the neurons form, they migrate out from the center to the outer edge by "crawling" along these radial fibers and dispersing laterally.

Cell migration, the third stage, places the neurons in precise layers and locations in the outside, or cortex, of the brain, and other locations where neurons establish themselves in concentrated areas (basal ganglia and cerebellum). Most neurogenesis and cell migration is complete within 4-5 months of conception.

Once the brain cells are formed and placed in designated locations, processes begin that collectively result in a complex brain capable of learning, emoting, calculating, creating and more.

Synaptogenesis and the establishment of neuronal networks connecting all parts of the nervous system is the fourth stage of development. This begins prior to birth but is active for decades. Neurons develop multiple extensions from the cell body (axons and dendrites), establish synapses where neurotransmitters from one cell can alter the internal state of another, and form complex networks of neurons to establish infrastructure that underlies brain function. Simultaneously, in a fifth process, nerve cells are "coated" with insulating material (myelin) to make electrical conduction more efficient.

Selective destruction is the sixth and last identified process that begins during the latter months of fetal life. During this stage, synapses and neurons are selectively destroyed: the initial burst of neurogenesis

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Homeless Veterans

According to the United States Department of Veterans Affairs, about one-third of the adult homeless population have served their country in the Armed Services. Current population estimates suggest that about 195,000 veterans (male and female) are homeless on any given night and perhaps twice as many experience homelessness at some point during the course of a year. Many other veterans are considered near homeless or at risk because of their poverty, lack of support from family and friends, and dismal living conditions in cheap hotels or in overcrowded or substandard housing.

In Montana, the number of people reporting veteran status during the annual Survey of the Homeless is much lower: in 2007, 272 persons (or about 12 percent) self-identified as veterans. Just 20 of those identified were women—or nearly 8 percent of those for whom gender was reported. The majority (70 percent) were single, and most were between the ages of 30 and 59. Just over half had diagnosed disabilities, the most common of which was a physical disability.

Source: US Department of Veterans Affairs (http://www1.va.gov/homeless/) and 2007 Survey of the Homeless (http://nth-degree.com/mthomeless).

The Brain Connection: Part II

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creates many more cells than are present in the adult human brain. By some estimates, 1/3 of the neurons present in the fetal brain are destroyed by genetically directed biochemical events. There is good evidence that without selective cell death (termed *apoptosis*), brain function is impaired. I like to think of this last stage as *pruning*. It appears that as cellular networks become specialized for specific brain functions, neurons that are redundant or not useful for that particular brain network are eliminated. Different brain areas have different timetables for this pruning process, but synaptic remodeling and selective cell destruction is crucial for normal brain function.

Although I have described brain development as six stages, three completed long prior to birth, it is important to conceptualize brain development as a cohesive process. As cells form centrally, they migrate outward to develop synapses and cellular networks. Functional networks develop and are remodeled all during our lives. As myelin ages, it is destroyed and new myelin is synthesized. Clusters of neurons and synaptic connections that were crucial to early stages of brain function are eliminated. The spatial localization and timing of all of this is genetically programmed and remains biologically unfinished until the late teens, if then.

The neuro-developmental research of the last 50 years has demonstrated the complexity of underlying mechanisms, with gene transcription, enzymes, growth factors, hormones, neurotransmitters, intracellular calcium regulation, and, no doubt, many yet-to-be-identified modulators playing a part. Given this level of complexity, it is not surprising that it is often impossible to identify the "why" of abnormal brain function.

Two types of abnormal brain development can be related to controllable external factors:

1. Abnormalities of the first stage of neural tube formation can be significantly decreased (perhaps by half) if women have adequate folate in their bodies at the time of conception. The mechanisms are not understood, but the intake of 400 micrograms/day of folic acid (a vitamin) by women who may become pregnant markedly decreases the occurrence of spina bifida. In women taking certain medications (e.g. valproate) or families where there is increased genetic risk, 10 times the amount of folate is recommended.
2. Fetal exposure to high concentrations of alcohol has serious effects on brain development. Fetal alcohol syndrome (specific facial features, microcephally, complex learning and behavioral problems), and the broader non-syndromic spectum of children whose mothers had chronic intake of alcohol during pregnancy is the most prevalent known cause of retardation. High alcohol exposure primarily affects the second and third stages of brain development.

Smoking during pregnancy may cause intrauterine growth impairment, likely from effects on placental blood vessels resulting in fetal malnutrition. Although there is concern about the effects of other drugs (prescription and illicit) on fetal brain development, no consistent patterns have been demonstrated.

What we do know about specific neuronal networks and neurotransmitters gives us a small window into some underpinnings of drug addiction, which is what I will tackle in Part III of the *Brain Connection*.

—Dr. Mary Anne Guggenheim attended Harvard Medical School in Boston, Massachusetts, and was trained in pediatrics and neurology. She was a full time faculty member at the University of Colorado School of Medicine in Denver until 1983, when she moved to Helena. For the next twelve years, Dr. Guggenheim had a statewide practice in child neurology. She retired from full-time practice in 1995. Since then, she has kept busy with participation on numerous state-level advisory groups and committees, has enjoyed her grandchildren, fly-fishing, and creating custom furniture.

Editor's note: This is the second in a multi-part series that Dr. Guggenheim has agreed to write for the Prevention Connection. This piece builds on the foundation laid by Part I of the series, which was printed in the fall issue of the newsletter. Check our next issue for the third Brain Connection article.

Traumatic brain injury within the homeless population

Traumatic brain injury (TBI) is common within the homeless population, and can be a cause or a consequence of homelessness. Homeless persons are at risk of brain injury due to exposure to violence, the high incidence of trauma and accidents, as well as the prevalence of substance abuse.

Physical characteristics of traumatic brain injuries include seizures, paralysis, poor coordination, weakness, headaches, and sensory problems. Cognitive impairments can include problems with concentration, memory, attention, reasoning and information processing. Victims may also have trouble with speech and language. Psychosocial characteristics of traumatic brain injuries may include fatigue, mood swings, loss of self or emotional control, trouble relating to others, sexual dysfunction, restlessness, anxiety and depression.

Living with HIV/AIDS

—Keri McWilliams and Christopher Peterson

—The challenges of homelessness are many. These challenges combined with a positive HIV/AIDS diagnosis can be devastating.

Although Montana is a rural and frontier state, we have not been untouched by the HIV/AIDS epidemic. According to the Montana Department of Health and Human Services (DPHHS), 789 HIV/AIDS cases were reported between 1985 and 2007. As of June 2007, 200 Montana adults were living with HIV and 286 with AIDS.

In response to the many associated challenges of living with this disease, the Yellowstone AIDS Project in Billings and the Missoula AIDS Council provide housing case management and prevention programs. The healthcare needs of people with HIV/AIDS are extensive and require a continuum of services. With access to current treatments, today's HIV positive individuals are living longer, healthier lives. A primary goal of the program is providing the healthiest standard of living for those whose lives are affected by HIV/AIDS. Providing access to housing is a primary objective in meeting this goal.

Many people living with this disease find themselves in need of housing assistance. In 1992, Congress funded the Housing Opportunities for Persons with AIDS (HOPWA) program. In 2002, DPHHS and private housing agencies in North and South Dakota, along with Yellowstone AIDS Project and Missoula AIDS Council were awarded the nation's first competitive, multi-state HOPWA grant.

The HOPWA program provides tenant-based rental assistance, emergency assistance, and housing coordination services to individuals living with HIV/AIDS. To qualify, individuals must have an HIV/AIDS diagnosis and earn less than 80 percent of the area median income. HOPWA services can include emergency assistance, rental assistance, and support services such as referrals to health care providers, counselors and nutrition programs.

AIDS Housing of Washington conducted an extensive needs assessment in Summer 2007. Seventy-eight of Montana's HOPWA participants responded. Of those, 13 percent had experienced homelessness within the past three years. Participants cited housing assistance, transportation and medical care as their top three needs. Several consumers have remarked that without this housing assistance, they would have been on the streets.

"Housing assistance is a godsend," says one Yellowstone AIDS Project client who receives assistance with rental payments. Like this individual, those who have trouble making rent and mortgage payments may receive assistance based on income level. Persons living with HIV who are homeless or at immediate risk of becoming homeless are provided with emergency assistance, such as access to hotel rooms. Montana's HOPWA projects can also provide bus and gas vouchers for transportation to and from medical appointments, work and school.

Housing stability is vital to preventing the spread of HIV. While no data has been released to date, staff at both projects report that clients with stable housing are more likely to access counseling services that address prevention.

In the past year, the Montana projects have helped move many HIV positive individuals from unstable living situations into permanent housing. Last year—in Western Montana alone—13 new HOPWA clients had either lived in emergency shelters, places unsuitable for human habitation or who had been couch surfing. Without assistance, finding housing can be a difficult task. In addition to the associated stigma, many people have poor credit ratings due to unpaid medical bills.

With HOPWA funding, we can provide case management and supportive services to help people secure safe, decent and affordable housing. This is a critical step in ensuring that our clients can focus on their health rather than working to survive on the streets. While emergency and rental assistance programs are intended to meet the basic needs of individuals who qualify for assistance, recovery and counseling services empower and promote self-sufficiency. The goal is to help people learn that HIV/AIDS is not the end of their lives, but a challenge to live fully in spite of it.

—Keri McWilliams is the Missoula AIDS Council Executive Director and Christopher Peterson, Missoula AIDS Council Housing Coordinator. Portions of this article were also contributed by Tasha LeClair, a Program Associate for the Yellowstone AIDS Project.

Living with HIV/AIDS

There are an estimated 40,000 new HIV infections in the United States each year.

Among more than 13,000 people living with HIV/AIDS surveyed by AIDS Housing of Washington since 1993, 40% indicated they had been homeless at some point in their lives.

Of the 2,217 unduplicated homeless persons identified during the 2007 Survey of the Homeless, 16 stated that one of the causes of their homelessness was HIV/AIDS.

Many homeless adolescents find that exchanging sex for food, clothing or shelter is their only chance of survival on the streets, significantly increasing their risk for contracting HIV.

For more information:

— *HOPWA: www.hud.gov/offices/cpd/aidshousing/programs/*

— *The Missoula AIDS Council: www.peopleshive.com*

— *The Yellowstone AIDS Project: http://www.yapmt.org/*

— *Current Montana HIV/AIDS data: Quarterly Summary of Montana's Reported Living HIV/AIDS Cases at http://hivdata.hhs.mt.gov/pdf/LIVINGAIDS062007.pdf*

Strengthening Montana

—Lt. Governor John Bohlinger

In the original movie version of Charles Dickens's *A Christmas Carole*, the Ghost of Christmas Present wore an opulent purple robe with an ermine collar. He was magnificent, carrying fruits and gifts, lavish with plenty. But at one point, the Ghost opened his robe to display gaunt, sunken–eyed twins. "Behold," he said. "These are our children, Hunger and Want."

It's easy to pretend that *Hunger* and *Want* don't exist in the midst of plenty, but they live among us every day, hidden by the trappings of a country that has been richly blessed. The desperately poor—whether housed or homeless—are often as close as the woman pouring coffee in the restaurant across the street. Hunger and Want tend to live their lives behind the scenes, largely invisible in the normal ebb and flow of our daily lives.

When we talk about Hunger and Want, each story is different, but there are common themes. When poverty is coupled with illness, disability or family crisis, the combination can catapult an individual—or a family—into homelessness. It happens far too often.

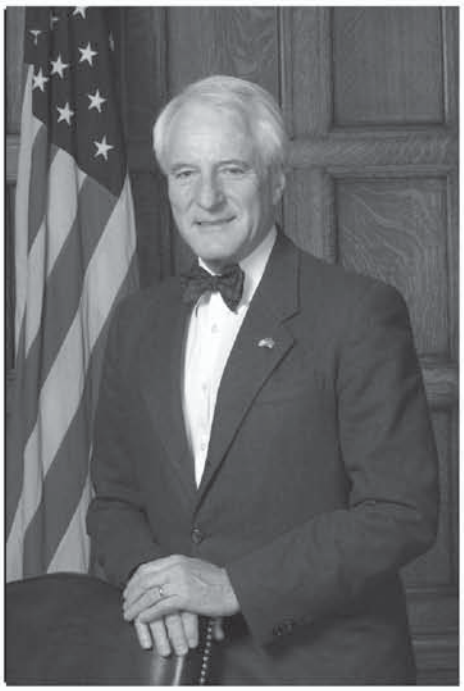
"Dawn" is a clerk at a local convenience store. Since she got her GED, she's been eking out almost enough for the basics: rent, food, gas and daycare. Then her daughter got sick and she had to miss two days of work. Dawn's boss had told her the month before that if she missed any more work, she'd lose her job. She was lucky this time: she just lost the days' pay. Unfortunately, that made her late coming up with the full amount of her rent and now her landlord is threatening eviction. With gas costing almost $3 a gallon, and the cost of winter heat projected to skyrocket, Dawn is not sure how long she can hang on. There's no margin for error, no room for rising costs in her budget. There's no family to turn to, and the only people she knows are those she works with. Unfortunately, most are in the same boat she is in.

"Michael's" story is completely different. He began hearing voices at age 17 and started drinking to quiet them down. He does pretty well while he's in the hospital for treatment, but once he gets out, he usually loses or runs out of his medication. The voices always come back. Michael is 39. He's never been able to hold a job for longer than a few weeks. He's been homeless and on our streets for the past ten years.

Dawn and Michael both live in Montana. They were born here, graduated from high school here. They are ours. Both are invisible.

On January 31, 2007, volunteers identified 2,217 homeless Montanans during Montana's annual *Survey of the Homeless*. Most had lived in the area for at least two years. Most had high school educations and many were working. Service providers say that this is the tip of the iceberg: many of those who are homeless in Montana exist beneath the radar of the programs designed to ensure that they don't fall through the cracks. They are sleeping on couches, in cars, in camps, county jails or hospitals, but fewer than five percent will resort to asking strangers for money.

The Schweitzer/Bohlinger Administration is committed to the kind of economic development that will provide better-paying jobs, housing and more education for people like Dawn. We are committed to ensuring that Montana has an exemplary mental health system that can offer people like Michael hope and recovery. As Co-Chair of the Governor's Council on Homelessness, I am deeply committed to addressing the issue of homelessness, at a personal level and as a partner in this very hopeful and progressive administration. Montana is on the move. We need to make sure that all the "Dawns" and "Michaels" of our state have the chance to move right along with the rest of us.



What works?

Not addressing homelessness—or addressing it only through temporary or emergency services—is an expensive nonsolution. Research indicates a strong likelihood that chronically homeless persons will use a variety of publicly funded services throughout the year. These include emergency rooms, short-term hospital stays, Health Care for the Homeless, jails, the State Hospital, transitional and/or emergency shelters.

When "housing first" strategies are employed and people move from the streets into permanent, supportive housing, about 90 percent can remain housed. In the past, supportive housing was considered prohibitively expensive, but it has emerged as a good investment, substantially reducing the use of other publicly funded services. In at least one study, the reduced use of acute care services nearly offset the costs of the permanent supportive housing.

The Last Word

—Joan Cassidy, Montana Chemical Dependency Bureau Chief

This issue of the *Prevention Connection* focuses on homelessness. Themes for recent issues have included alcohol, mental health and poverty. Each set forth some of the complexities of the topic and showcased some of the strategies playing out with success in Montana's communities. The topic of homelessness, however, includes components all of these and more.

We are *all* affected by homelessness. The issues that lead to—and sustain—homelessness come together in a complicated tangle, at personal and overarching levels. People who are homeless typically struggle with a range of vulnerabilities, including backgrounds of significant childhood trauma; persistent, crisis poverty; a range of disabilities (e.g., mental illness, substance abuse disorders, co-occurring disorders, physical and developmental disabilities); lack of education and training; poor credit histories; and/or criminal records. Any one of these issues can be the root problem—or the trigger—for a downhill slide that ultimately ends in homelessness.

The annual Survey of the Homeless, undertaken by the Intergovernmental Human Services Bureau of DPHHS and the HRDC Directors' Association, suggests a connection between substance abuse and addictive disorders, mental illness, co-occurring disorders...and homelessness. Of course, not every homeless person struggles with mental health and/or substance abuse issues, but many do. Volunteer surveyors on the night of January 31, 2007 identified 2,217 unduplicated homeless Montanans of all ages. Of those, 842 stated that they had been diagnosed with one or more disabilities: 402 with a mental illness and 234 with a substance abuse disorder. When asked to specify some of the causes of their homelessness, the connection became even clearer: 485 respondents stated that substance abuse had contributed to their homelessness; 298 reported that mental illness had played a role. This is not a census, but the survey does provide some important insights in the strategies we'll need to address the problem.

No one solution can solve homelessness. Readily accessible chemical dependency and mental health treatment are needed, as is case management, but those won't work in a vacuum. More affordable housing is needed, but that alone will not solve the problem, either. Violence- and crime-prevention strategies and strong schools all contribute to lasting solutions. Prevention in this case is an intricate mosaic comprised of housing, income, education, jobs, treatment . . . the enhancement of community assets and the reduction of risk factors, one of which is the stigma associated with mental illness, chemical dependency . . . and homelessness. To solve this problem means taking a deliberate and thoughtful approach to prevention, and to ensuring that services and housing are available to individuals and families . . . no matter where they find themselves sleeping.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

A joint publication of the ***Prevention Resource Center*** *and the* ***Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

2,500 copies of this public document were published at an estimated cost of $2.98 per copy, for a total cost of $7,460.00, which includes $3,460.00 for production and printing and $4,000.00 for distribution.

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Helena, MT 59604

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